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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02673

2685

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Calvert		MARYLAND		STATE Maryland		COUNTY Calvert	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Willows		LENGTH OF STAY (in this place) 8 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Willows			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) Rosanna Carton				4. DATE OF DEATH (Month) (Day) (Year) March 14 1956			
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH April 1, 1872		9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Dublin, Ireland		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>	
13. FATHER'S NAME Dennis McGuire				14. MOTHER'S MAIDEN NAME Mary Connelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Box 217 P. Thomas Carton, North Beach, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <i>Hypertensive C.V.R. disease</i> ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) STATING UNDERLYING CAUSE LAST.						INTERVAL BETWEEN ONSET AND DEATH 	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March 13, 1956</i> to <i>3/14, 1956</i> that I last saw the deceased alive on <i>3/13, 1956</i> and that death occurred at <i>3:14 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>A. J. Weems</i> ADDRESS (Street, city, town, state) <i>Huntingtown, Md.</i> DATE SIGNED <i>3/14/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 16 / 56		NAME OF CEMETERY OR CREMATORY Mt. Harmony		LOCATION (City, town, or county) (State) nr. Owings, Maryland	
24. REC'D BY REGISTRAR DATE Mar. 15, 1956		REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. D. Hutchins</i> ADDRESS Owings, Md.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HARRIS	2. SEX Male	3. AGE 45	4. DATE OF BIRTH 1910
5. PLACE OF BIRTH New York, N.Y.	6. OCCUPATION Salesman	7. MARITAL STATUS Married	8. DATE OF DEATH 1956
9. CAUSE OF DEATH Heart Disease	10. PLACE OF DEATH Home	11. SIGNATURE OF DECEASED (None)	12. SIGNATURE OF WITNESSES (None)

13. NAME OF PHYSICIAN Dr. J. H. Smith	14. NAME OF HOSPITAL St. Mary's Hospital	15. NAME OF NURSE Mrs. J. H. Smith	16. NAME OF MINISTER Rev. J. H. Smith
17. NAME OF CORONER Mr. J. H. Smith	18. NAME OF JURY None	19. NAME OF JURY None	20. NAME OF JURY None
21. NAME OF JURY None	22. NAME OF JURY None	23. NAME OF JURY None	24. NAME OF JURY None

25. NAME OF JURY None	26. NAME OF JURY None	27. NAME OF JURY None	28. NAME OF JURY None
29. NAME OF JURY None	30. NAME OF JURY None	31. NAME OF JURY None	32. NAME OF JURY None
33. NAME OF JURY None	34. NAME OF JURY None	35. NAME OF JURY None	36. NAME OF JURY None

37. NAME OF JURY None	38. NAME OF JURY None	39. NAME OF JURY None	40. NAME OF JURY None
41. NAME OF JURY None	42. NAME OF JURY None	43. NAME OF JURY None	44. NAME OF JURY None
45. NAME OF JURY None	46. NAME OF JURY None	47. NAME OF JURY None	48. NAME OF JURY None

49. NAME OF JURY None	50. NAME OF JURY None	51. NAME OF JURY None	52. NAME OF JURY None
53. NAME OF JURY None	54. NAME OF JURY None	55. NAME OF JURY None	56. NAME OF JURY None
57. NAME OF JURY None	58. NAME OF JURY None	59. NAME OF JURY None	60. NAME OF JURY None

61. NAME OF JURY None	62. NAME OF JURY None	63. NAME OF JURY None	64. NAME OF JURY None
65. NAME OF JURY None	66. NAME OF JURY None	67. NAME OF JURY None	68. NAME OF JURY None
69. NAME OF JURY None	70. NAME OF JURY None	71. NAME OF JURY None	72. NAME OF JURY None

BUREAU V. S.

MAR 20 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2686

CERTIFICATE OF DEATH

02674

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Calvert		STATE Maryland		COUNTY Calvert			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Owings		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Owings			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) MARTIN LUTHER CATTERTON				4. DATE OF DEATH (Month) (Day) (Year) Mar. 17 19 56			
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 23, 1910		9. AGE last birthday 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Oden Catterton				14. MOTHER'S MAIDEN NAME Georgianna Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) _ _ _		16. SOCIAL SECURITY NO. 218-12-9016		17. INFORMANT & ADDRESS Mr. George Catterton, Owings, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
159X IMMEDIATE CAUSE (A) <i>Carcinoma of G. I. tract exact location of origin undetermined</i>						INTERVAL BETWEEN ONSET AND DEATH <i>August 1953</i>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Essential Lupus Erythematosus</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug</i>, 19<i>55</i>, to <i>March 17</i>, 19<i>56</i>, that I last saw the deceased alive on <i>March 7</i>, 19<i>56</i>, and that death occurred at <i>11:45</i> M., from the causes and on the date stated above.							
SIGNATURE <i>George L. Hutchins</i>		M.D. <i>James J. Redenbach</i>		DATE SIGNED <i>3/18/56</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>3/20/56</i>		NAME OF CEMETERY OR CREMATORY <i>Int Harmony</i>		LOCATION (City, town, or county) (State) <i>Md Owings Md</i>	
24. REC'D BY REGISTRAR <i>Grace L. Hutchins</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Hutchins</i>		ADDRESS <i>Owings Md</i>	
DATE <i>3/19/56</i>							

CERTIFICATE OF DEATH

6838

Rev. 1954, 10-15

NAME OF DECEASED O. J. Davis		SEX Male		RACE White	
DATE OF DEATH 1-15-55		PLACE OF DEATH Baltimore, Md.		COUNTY Baltimore	
TIME OF DEATH 10:00 AM		PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH 1-15-1910	
CAUSE OF DEATH Coronary Thrombosis		MANNER OF DEATH Natural		PLACE OF INTERMENT St. George's Cemetery, Baltimore, Md.	
SIGNATURE OF PHYSICIAN J. Edgar Smith, M.D.		SIGNATURE OF REGISTRAR J. Edgar Smith, M.D.		SIGNATURE OF WITNESSES J. Edgar Smith, M.D.	
SIGNATURE OF DECEASED O. J. Davis		SIGNATURE OF NEXT OF KIN J. Edgar Smith, M.D.		SIGNATURE OF CLERK J. Edgar Smith, M.D.	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give name of funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. The pages may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnston</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnston</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Zany</u> First <u>Cole</u> Middle <u>Cole</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/56</u>
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u>17</u>	IF UNDER 24 HRS. Hours <u>17</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fredrick Cole</u>		14. MOTHER'S MAIDEN NAME <u>Maynard Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Maynard Harris</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO <u>772.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Poor Case</u> DUE TO <u>Was delirious in H. Discharged in good condition</u> (c) <u>Was delirious in H. Discharged in good condition</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unmarried parents with poor care</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <u>Not while</u> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>3-23-56</u>		<u>3-23-56</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Carrolls</u>		<u>Barnston Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>P. E. Sewell. Dr. Fred. Md.</u>		<u>2-23-56</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>DATE</u>		<u>H. W. Ward</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02676

2688 **CERTIFICATE OF DEATH**

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Calvert		MARYLAND		STATE Maryland		COUNTY Calvert	
CITY (If outside corporate limits, write RURAL and give nearest town) OR Prince Frederick		LENGTH OF STAY (in this place) 7 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR Huntingtown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Calvert County Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) CORA WILSON CRANFORD				4. DATE OF DEATH (Month) March (Day) 5 (Year) 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH November 11, 1864	9. AGE last birthday 91 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY same		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David I. Bowen				14. MOTHER'S MAIDEN NAME Mary Elizabeth Ireland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT & ADDRESS Mrs. Julius O. Bowen, Huntingtown, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) generalized arterio-sclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-29-56</u>, to <u>3-5-56</u>, that I last saw the deceased alive on <u>March 5, 1956</u>, and that death occurred at <u>5 p</u> M, from the causes and on the date stated above.							
SIGNATURE <i>Rd Williams</i>				ADDRESS (Street, city, town, state) <i>St. Henri</i>		DATE SIGNED <i>3/6/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 7, 1956		NAME OF CEMETERY OR CREMATORY Huntingtown Cemetery		LOCATION (City, town, or county) (State) Huntingtown, Md.	
24. REC'D BY REGISTRAR DATE Mar. 6, 1956		REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Hutchins</i> ADDRESS Owings, Maryland			

2004 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

120072

NAME OF DECEASED: **John Edward Smith**
 SEX: **Male** AGE: **70** DATE OF BIRTH: **11/11/1934**
 PLACE OF BIRTH: **Baltimore, Maryland**
 OCCUPATION: **Retired**
 MARITAL STATUS: **Married**
 DECEASED AT: **Home** DATE OF DEATH: **11/11/2004**
 CAUSE OF DEATH: **Heart Disease**

DATE OF DEATH: **11/11/2004**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **Home**
 DECEASED AT: **Home**
 CAUSE OF DEATH: **Heart Disease**
 MANNER OF DEATH: **Natural**

DATE OF DEATH: **11/11/2004**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **Home**
 DECEASED AT: **Home**
 CAUSE OF DEATH: **Heart Disease**
 MANNER OF DEATH: **Natural**

DATE OF DEATH: **11/11/2004**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **Home**
 DECEASED AT: **Home**
 CAUSE OF DEATH: **Heart Disease**
 MANNER OF DEATH: **Natural**

DATE OF DEATH: **11/11/2004**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **Home**
 DECEASED AT: **Home**
 CAUSE OF DEATH: **Heart Disease**
 MANNER OF DEATH: **Natural**

DATE OF DEATH: **11/11/2004**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **Home**
 DECEASED AT: **Home**
 CAUSE OF DEATH: **Heart Disease**
 MANNER OF DEATH: **Natural**

RECEIVED
BUREAU V. S.
MAR 12 1956

INSTRUCTIONS

02677 51

2689

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>0222 21</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Oden</u> Middle <u>W.</u> Last <u>Elliott</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1956</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/1894</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>61</u> Days <u>18</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Martha Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. Bessie Elliott</u>		Address <u>Deale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u> DUE TO (c) <u>Admission of G. E. Grant</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Has been bedridden for several years</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>3/10/56</u> 19 <u>56</u> , to <u>3/18</u> 19 <u>56</u> , that I last saw the deceased alive on <u>3/18</u> 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard</u>				ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type)				M.D. <u>Orwings</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlands</u>		22d. LOCATION (City, town, or county) (State) <u>Galesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard C. Hardisty</u>				ADDRESS <u>Salisbury</u>		24a. REC'D BY REGISTRAR DATE <u>23 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Hugh Hardisty</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1956 23 APR 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-18 2690 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02679

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u> d. STREET ADDRESS <u>GROVER</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Robert William Robert Grover Jr</u>				4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1956</u>															
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 12, 1945</u>		9. AGE (In years last birthday) <u>10</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>5</u></td> <td><u>37</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>5</u>	<u>37</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
<u>5</u>	<u>37</u>																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>													
13. FATHER'S NAME <u>William Robert Grover</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Louise McCready</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Wesley McCready Tushy</u> Address <u>—</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Collapsed chest with hemorrhage</u> DUE TO <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was hit when he was going down #2</u>																			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>																	
20c. TIME OF INJURY Month, Day, Year <u>4/10</u> <u>3/9</u> <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Road</u>		20f. (City or town) (County) (State) <u>Solomons Calvert MD</u>													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>H W Ward</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>															
EXAMINER'S NAME (Type) <u>H W Ward</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>															
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/9/56</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tushy - Calvert Co - MD</u>													
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness & Son - Mutual, Ind.</u>				24a. REC'D BY REGISTRAR <u>3-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.
MAR 13 1956

RECEIVED
MAR 13 1956

2691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8, Film G195 11-6-56 et

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u> c. LENGTH OF STAY IN 1b <u>Island Creek</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Island Creek</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u> d. STREET ADDRESS <u>Island Creek</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Gantt</u> Middle <u>Gantt</u> Last <u>Gantt</u> 4. DATE OF DEATH <u>3</u> Month <u>26</u> Day <u>1956</u> Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>E</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1879</u> 9. AGE (In years, top birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Island Creek</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Thomas Gantt</u> 14. MOTHER'S MAIDEN NAME <u>Mathe Gantt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Mathe Gantt</u> 17. INFORMANT <u>Island Creek</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary embolism</u> 420.1 DUE TO <u>May been sailing for sometime 2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral aneurysm</u> (c) <u>Cerebral aneurysm</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was fairly good, got up dressed, collapsed at 5:15 p.m. at 10:30</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>at 10:30</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>10</u> a. m. <u>30</u> p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Island Creek</u> 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>H W Ward</u> EXAMINER'S NAME (Type) <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-1-56</u> 22b. DATE THEREOF <u>4-1-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Brooke</u> 22d. LOCATION (City, town, or county) (State) <u>Island Creek Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Fred, Md</u> ADDRESS <u>Island Creek Md</u> 24a. REC'D BY REGISTRAR <u>3-28-56</u> 24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 29 1956

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. CAUSE OF DEATH: _____
8. MANNER OF DEATH: _____
9. SIGNATURE OF MEDICAL EXAMINER: _____
10. DATE OF EXAMINATION: _____

11. SIGNATURE OF REGISTRAR: _____
12. DATE OF REGISTRATION: _____

13. SIGNATURE OF CLERK: _____
14. DATE OF ENTRY: _____

15. SIGNATURE OF CHIEF CLERK: _____
16. DATE OF ENTRY: _____

17. SIGNATURE OF ASSISTANT CLERK: _____
18. DATE OF ENTRY: _____

19. SIGNATURE OF ASSISTANT CLERK: _____
20. DATE OF ENTRY: _____

21. SIGNATURE OF ASSISTANT CLERK: _____
22. DATE OF ENTRY: _____

23. SIGNATURE OF ASSISTANT CLERK: _____
24. DATE OF ENTRY: _____

25. SIGNATURE OF ASSISTANT CLERK: _____
26. DATE OF ENTRY: _____

27. SIGNATURE OF ASSISTANT CLERK: _____
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96. DATE OF ENTRY: _____

97. SIGNATURE OF ASSISTANT CLERK: _____
98. DATE OF ENTRY: _____

99. SIGNATURE OF ASSISTANT CLERK: _____
100. DATE OF ENTRY: _____

1

2692 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Calvert</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Prince Frederick</i>		LENGTH OF STAY (in this place) <i>15 min.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chesapeake Beach, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Bell</i> (First) <i>Hubbard</i> (Middle) (Last)				4. DATE OF DEATH (Month) <i>3</i> (Day) <i>7</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3/31/1888</i>	9. AGE last birthday <i>67</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Samuel Somers</i>				14. MOTHER'S MAIDEN NAME <i>Ann Moore</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>MR. Collie Hubbard</i> <i>Chesapeake Beach, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
433.1 IMMEDIATE CAUSE (A) <i>Auricular Fibillation</i>						INTERVAL BETWEEN ONSET AND DEATH <i>five day.</i>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10 Feb</i> , 19 <i>53</i> , to <i>7 Mar</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>7 Mar</i> , 19 <i>56</i> , and that death occurred at <i>9:15</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>H. W. Ward</i>				DATE SIGNED <i>7 Mar 56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Mar 10</i>		NAME OF CEMETERY OR CREMATORY <i>Efford Md</i>		LOCATION (City, town, or county) (State) <i>Efford Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Newnam</i>		ADDRESS	
DATE <i>3-7-56</i>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

2693

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWENS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowens</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bowens</u>				d. STREET ADDRESS <u>Bowens</u>			
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Victoria</u> Last <u>Hutchins</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 April, 1880</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Bowens</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas W. Hall</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Hutchins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>John W. Hutchins</u>				Address <u>Bowens, Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure - Coronary Thrombosis</u>							<u>1 yr.</u>
420.1 DUE TO (b) <u>Hyper-tensive Cardio-vascular Disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>27 March 1955</u> to <u>15 March 1956</u> , that I last saw the deceased alive on <u>15 March 1956</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas M. Hutchins</u>				ADDRESS (Street, city or town, state) <u>7315 Landover Rd Hyattsville, Ind 47040</u>			
DATE SIGNED <u>24 March 1956</u>							
PHYSICIAN'S NAME (Type) <u>THOMAS M. HUTCHINS</u>				ADDRESS <u>7315 LANDOVER ROAD - HYATTSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 27, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barstow - Calvert Co - Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackness & Son - Mutual, Ind</u>				ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>3-26-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

2694

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

038250
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabret</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cabret</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solomons</u>		
c. LENGTH OF STAY IN 1b <u>3 days</u>			d. STREET ADDRESS _____		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>L.</u> Last <u>Selby</u>			4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1873</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Cabret County, Md.</u>	
13. FATHER'S NAME <u>William Selby</u>			14. MOTHER'S MAIDEN NAME <u>Matilda Cullember</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-01-1081</u>		17. INFORMANT <u>W. Edward Selby - Solomons, Ind.</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO <u>Carcinoma Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from <u>Sept - 1954</u> to <u>Mar - 1956</u> that I last saw the deceased alive on <u>Mar - 25 - 1956</u> and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>E. S. Coster</u>		ADDRESS (Street, city or town, state) <u>Solomons, Md.</u>		DATE SIGNED <u>3/28/56</u>	
PHYSICIAN'S NAME (Type) <u>E. S. COSTER</u>		ADDRESS <u>SOLOMONS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 28, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist</u>		22d. LOCATION (City, town, or county) <u>Solomons, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Ind.</u>		ADDRESS _____		24a. REC'D BY REGISTRAR <u>3/28/56</u> DATE _____	
				24b. REGISTRAR'S SIGNATURE <u>E. S. Coster</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.
 APR 11 1956

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		THIRD OF DEATH	
FOURTH OF DEATH		FIFTH OF DEATH		SIXTH OF DEATH		SEVENTH OF DEATH		EIGHTH OF DEATH		NINTH OF DEATH	
TENTH OF DEATH		ELEVENTH OF DEATH		TWELFTH OF DEATH		THIRTEENTH OF DEATH		FOURTEENTH OF DEATH		FIFTEENTH OF DEATH	
SIXTEENTH OF DEATH		SEVENTEENTH OF DEATH		EIGHTEENTH OF DEATH		NINETEENTH OF DEATH		TWENTIETH OF DEATH		TWENTY-FIRST OF DEATH	
TWENTY-SECOND OF DEATH		TWENTY-THIRD OF DEATH		TWENTY-FOURTH OF DEATH		TWENTY-FIFTH OF DEATH		TWENTY-SIXTH OF DEATH		TWENTY-SEVENTH OF DEATH	
TWENTY-EIGHTH OF DEATH		TWENTY-NINTH OF DEATH		THIRTIETH OF DEATH		THIRTY-FIRST OF DEATH		THIRTY-SECOND OF DEATH		THIRTY-THIRD OF DEATH	
THIRTY-FOURTH OF DEATH		THIRTY-FIFTH OF DEATH		THIRTY-SIXTH OF DEATH		THIRTY-SEVENTH OF DEATH		THIRTY-EIGHTH OF DEATH		THIRTY-NINTH OF DEATH	
FORTY OF DEATH		FORTY-FIRST OF DEATH		FORTY-SECOND OF DEATH		FORTY-THIRD OF DEATH		FORTY-FOURTH OF DEATH		FORTY-FIFTH OF DEATH	
FORTY-SIXTH OF DEATH		FORTY-SEVENTH OF DEATH		FORTY-EIGHTH OF DEATH		FORTY-NINTH OF DEATH		FIFTY OF DEATH		FIFTY-FIRST OF DEATH	
FIFTY-SECOND OF DEATH		FIFTY-THIRD OF DEATH		FIFTY-FOURTH OF DEATH		FIFTY-FIFTH OF DEATH		FIFTY-SIXTH OF DEATH		FIFTY-SEVENTH OF DEATH	
FIFTY-EIGHTH OF DEATH		FIFTY-NINTH OF DEATH		SIXTY OF DEATH		SIXTY-FIRST OF DEATH		SIXTY-SECOND OF DEATH		SIXTY-THIRD OF DEATH	
SIXTY-FOURTH OF DEATH		SIXTY-FIFTH OF DEATH		SIXTY-SIXTH OF DEATH		SIXTY-SEVENTH OF DEATH		SIXTY-EIGHTH OF DEATH		SIXTY-NINTH OF DEATH	
SEVENTY OF DEATH		SEVENTY-FIRST OF DEATH		SEVENTY-SECOND OF DEATH		SEVENTY-THIRD OF DEATH		SEVENTY-FOURTH OF DEATH		SEVENTY-FIFTH OF DEATH	
SEVENTY-SIXTH OF DEATH		SEVENTY-SEVENTH OF DEATH		SEVENTY-EIGHTH OF DEATH		SEVENTY-NINTH OF DEATH		EIGHTY OF DEATH		EIGHTY-FIRST OF DEATH	
EIGHTY-SECOND OF DEATH		EIGHTY-THIRD OF DEATH		EIGHTY-FOURTH OF DEATH		EIGHTY-FIFTH OF DEATH		EIGHTY-SIXTH OF DEATH		EIGHTY-SEVENTH OF DEATH	
EIGHTY-EIGHTH OF DEATH		EIGHTY-NINTH OF DEATH		NINETY OF DEATH		NINETY-FIRST OF DEATH		NINETY-SECOND OF DEATH		NINETY-THIRD OF DEATH	
NINETY-FOURTH OF DEATH		NINETY-FIFTH OF DEATH		NINETY-SIXTH OF DEATH		NINETY-SEVENTH OF DEATH		NINETY-EIGHTH OF DEATH		NINETY-NINTH OF DEATH	
HUNDRED OF DEATH		HUNDRED-FIRST OF DEATH		HUNDRED-SECOND OF DEATH		HUNDRED-THIRD OF DEATH		HUNDRED-FOURTH OF DEATH		HUNDRED-FIFTH OF DEATH	
HUNDRED-SIXTH OF DEATH		HUNDRED-SEVENTH OF DEATH		HUNDRED-EIGHTH OF DEATH		HUNDRED-NINTH OF DEATH		HUNDRED-TENTH OF DEATH		HUNDRED-ELEVENTH OF DEATH	
HUNDRED-TWELTH OF DEATH		HUNDRED-THIRTEENTH OF DEATH		HUNDRED-FOURTEENTH OF DEATH		HUNDRED-FIFTEENTH OF DEATH		HUNDRED-SIXTEENTH OF DEATH		HUNDRED-SEVENTEENTH OF DEATH	
HUNDRED-EIGHTEENTH OF DEATH		HUNDRED-NINETEENTH OF DEATH		HUNDRED-TWENTY OF DEATH		HUNDRED-TWENTY-FIRST OF DEATH		HUNDRED-TWENTY-SECOND OF DEATH		HUNDRED-TWENTY-THIRD OF DEATH	
HUNDRED-TWENTY-FOURTH OF DEATH		HUNDRED-TWENTY-FIFTH OF DEATH		HUNDRED-TWENTY-SIXTH OF DEATH		HUNDRED-TWENTY-SEVENTH OF DEATH		HUNDRED-TWENTY-EIGHTH OF DEATH		HUNDRED-TWENTY-NINTH OF DEATH	
HUNDRED-THIRTY OF DEATH		HUNDRED-THIRTY-FIRST OF DEATH		HUNDRED-THIRTY-SECOND OF DEATH		HUNDRED-THIRTY-THIRD OF DEATH		HUNDRED-THIRTY-FOURTH OF DEATH		HUNDRED-THIRTY-FIFTH OF DEATH	
HUNDRED-THIRTY-SIXTH OF DEATH		HUNDRED-THIRTY-SEVENTH OF DEATH		HUNDRED-THIRTY-EIGHTH OF DEATH		HUNDRED-THIRTY-NINTH OF DEATH		HUNDRED-FORTY OF DEATH		HUNDRED-FORTY-FIRST OF DEATH	
HUNDRED-FORTY-SECOND OF DEATH		HUNDRED-FORTY-THIRD OF DEATH		HUNDRED-FORTY-FOURTH OF DEATH		HUNDRED-FORTY-FIFTH OF DEATH		HUNDRED-FORTY-SIXTH OF DEATH		HUNDRED-FORTY-SEVENTH OF DEATH	
HUNDRED-FORTY-EIGHTH OF DEATH		HUNDRED-FORTY-NINTH OF DEATH		HUNDRED-FIFTY OF DEATH		HUNDRED-FIFTY-FIRST OF DEATH		HUNDRED-FIFTY-SECOND OF DEATH		HUNDRED-FIFTY-THIRD OF DEATH	
HUNDRED-FIFTY-FOURTH OF DEATH		HUNDRED-FIFTY-FIFTH OF DEATH		HUNDRED-FIFTY-SIXTH OF DEATH		HUNDRED-FIFTY-SEVENTH OF DEATH		HUNDRED-FIFTY-EIGHTH OF DEATH		HUNDRED-FIFTY-NINTH OF DEATH	
HUNDRED-SIXTY OF DEATH		HUNDRED-SIXTY-FIRST OF DEATH		HUNDRED-SIXTY-SECOND OF DEATH		HUNDRED-SIXTY-THIRD OF DEATH		HUNDRED-SIXTY-FOURTH OF DEATH		HUNDRED-SIXTY-FIFTH OF DEATH	
HUNDRED-SIXTY-SIXTH OF DEATH		HUNDRED-SIXTY-SEVENTH OF DEATH		HUNDRED-SIXTY-EIGHTH OF DEATH		HUNDRED-SIXTY-NINTH OF DEATH		HUNDRED-SEVENTY OF DEATH		HUNDRED-SEVENTY-FIRST OF DEATH	
HUNDRED-SEVENTY-SECOND OF DEATH		HUNDRED-SEVENTY-THIRD OF DEATH		HUNDRED-SEVENTY-FOURTH OF DEATH		HUNDRED-SEVENTY-FIFTH OF DEATH		HUNDRED-SEVENTY-SIXTH OF DEATH		HUNDRED-SEVENTY-SEVENTH OF DEATH	
HUNDRED-SEVENTY-EIGHTH OF DEATH		HUNDRED-SEVENTY-NINTH OF DEATH		HUNDRED-EIGHTY OF DEATH		HUNDRED-EIGHTY-FIRST OF DEATH		HUNDRED-EIGHTY-SECOND OF DEATH		HUNDRED-EIGHTY-THIRD OF DEATH	
HUNDRED-EIGHTY-FOURTH OF DEATH		HUNDRED-EIGHTY-FIFTH OF DEATH		HUNDRED-EIGHTY-SIXTH OF DEATH		HUNDRED-EIGHTY-SEVENTH OF DEATH		HUNDRED-EIGHTY-EIGHTH OF DEATH		HUNDRED-EIGHTY-NINTH OF DEATH	
HUNDRED-NINETY OF DEATH		HUNDRED-NINETY-FIRST OF DEATH		HUNDRED-NINETY-SECOND OF DEATH		HUNDRED-NINETY-THIRD OF DEATH		HUNDRED-NINETY-FOURTH OF DEATH		HUNDRED-NINETY-FIFTH OF DEATH	
HUNDRED-NINETY-SIXTH OF DEATH		HUNDRED-NINETY-SEVENTH OF DEATH		HUNDRED-NINETY-EIGHTH OF DEATH		HUNDRED-NINETY-NINTH OF DEATH		HUNDRED OF DEATH		HUNDRED-FIRST OF DEATH	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02683

Item 9, Film 0194 3-23-56 et

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary C Strater</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>James Strater</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virginia Gray Sunderland Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>1142</u> a. m. <u>3/16</u> p. m. <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/16/56</u>	
EXAMINER'S NAME (Type) <u>H. W. Ward, D.M.E.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-19-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooks</u>		22d. LOCATION (City, town, or county) (State) <u>Island Creek Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. C. Small Pinner</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>3-19-56</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>			

NAME OF DECEASED	DATE OF DEATH
AGE	SEX
PLACE OF BIRTH	DATE OF BIRTH
EDUCATION	RELIGION
USUAL OCCUPATION	CAUSE OF DEATH
IMMEDIATE CAUSE OF DEATH	UNDERLYING CAUSE OF DEATH
IMMEDIATE CAUSE OF DEATH	UNDERLYING CAUSE OF DEATH

Oct 1 1956

James Alexander
Lived in Maryland 2 years and 3 months

BUREAU V. S.

MAR 20 1956

RECEIVED

General Clerk and

Director

3-18-55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2696 CERTIFICATE OF DEATH

02678

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <u>Barstow, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Edward</u> <u>Joye</u>				<u>3-31-1956</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Joye</u>				14. MOTHER'S MAIDEN NAME <u>Harriet White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Thornton Joye Prince Fred</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/30</u> , 19 <u>56</u> , to <u>3/31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>56</u> , and that death occurred at <u>10:41</u> M., from the causes and on the date stated above.							
SIGNATURE <u>R. Williams</u> M.D.				ADDRESS (Street, city, town, state) <u>St. Thomas</u> DATE SIGNED <u>4/3</u>			
23. (BURIAL, CREMATION, REMOVAL) (SPECIFY)		DATE THEREOF <u>4-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>Carroll</u>		LOCATION (City, town, or county) (State) <u>Barstow, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Pr. Fred, Md.</u>	
DATE <u>4/3/56</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2697 **CERTIFICATE OF DEATH**

02684

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Calvert		STATE MARYLAND		COUNTY Calvert			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sunderland		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sunderland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) WILLIAM SAMUEL TURNER				4. DATE OF DEATH (Month) (Day) (Year) March 15 19 56			
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH January 26, 1887		9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Turner				14. MOTHER'S MAIDEN NAME Ida Virginia Marquess			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-36-7322		17. INFORMANT & ADDRESS Mrs. Wm. Turner, Sunderland, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 420.1 CORONARY OCCLUSION						INTERVAL BETWEEN ONSET AND DEATH 28 hours	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Gastric ulcer						19.50	
(C) Varicose veins of both legs							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 19 54, to March 15, 19 56, that I last saw the deceased alive on March 15, 19 56, and that death occurred at 7 A.M. from the causes and on the date stated above.							
SIGNATURE <i>Grace L. Nutsch</i>		M.D. <i>Grace L. Nutsch</i>		ADDRESS (Street, city, town, state) <i>Prince Georges</i>		DATE SIGNED <i>3/16/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 17 / 56		NAME OF CEMETERY OR CREMATORY Mt. Harmony Cemetery		LOCATION (City, town, or county) (State) Owings, Maryland	
24. REC'D BY REGISTRAR DATE 3/17/56		REGISTRAR'S SIGNATURE <i>Grace L. Nutsch</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Hutchins</i>		ADDRESS <i>Owings Md</i>	

5529-6C-85R

BUREAU V. S.

MAR 22 1956

RECEIVED

2698

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>Cabnet</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Cabnet</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Solomons</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>00</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Sarah Elizabeth Webster</i>		4. DATE OF DEATH Month Day Year <i>Mar. 11, 1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26, 1873</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR: Months Days Hours Min. <i>9 15</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John G. Saunders</i>		14. MOTHER'S MAIDEN NAME <i>Sarah E. Vaughan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>H. B. Glascock - Solomons, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis C.V. disease</i> DUE TO (c) <i>5 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> 1955, to <i>March 11, 1956</i> , that I last saw the deceased alive on <i>Feb 20</i> 1956, and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Prince Frederick, Md.</i>			
ACTUAL SIGNATURE <i>Prince Frederick</i>		M.D. <i>Prince Frederick</i>	
PHYSICIAN'S NAME (Type) <i>PAGE C. JETT</i>		<i>PRINCE FREDERICK, M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Mar. 13, 1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Middleham Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Fusby - Cabnet Co - Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Md.</i>		ADDRESS <i>3-13-56</i>	
24a. REC'D BY REGISTRAR <i>3-13-56</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 1 4 MAR

RECEIVED